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July 13, 2012

Toby Douglas
Director
Department of Health Care Services
Sacramento, CA

Re: ***Low Income Health Program Draft Transition Plan***

Dear Mr. Douglas:

The Low Income Health Program (LIHP) has been a tremendous step towards enrolling a large portion of those who will be Medicaid eligible in 2014. A successful transition from LIHP to Medi-Cal will give California a head start on ensuring the enrollment of as many as 500,000 newly eligible under the Affordable Care Act (ACA).

Community Health Councils (CHC) is a community-based health promotion, policy and advocacy organization that is committed to improving health and increasing access to quality healthcare for uninsured, under-resourced and under-served populations by convening broad based coalitions. Our recommendations for the LIHP transition are based on these priorities and objectives:

1. The preservation of choice and access to affordable coverage
2. Minimal or no disruption in continuity of coverage and medical care
3. Equitable access to providers for all LIHP enrollees
4. Simple, efficient enrollment and retention processes that are integrated with the ACA to streamline health coverage
5. A strong infrastructure for consumer-focused implementation, communication and education.

Some of the LIHP enrollees will move to the Exchange. While our comments are focused primarily on those who will transition to Medi-Cal, many of the issues and recommendations can apply to both groups.

1. The preservation of choice and access to affordable coverage

LIHP enrollees deemed eligible for Medi-Cal should be given the opportunity to "opt-in" to a managed care plan by choosing their own health plan rather than having to wait to "opt-out" after they have been assigned to a managed care plan. Many LIHP enrollees live below the poverty level and experience challenges in accessing health services such as transportation, scheduling, and language barriers. We recommend that, as with the Seniors and Persons with Disabilities (SPD) transition, beneficiaries whose providers are not in the network be given the option of choosing a plan and provider first. The Department of Health Care Services (DHCS) should only assign beneficiaries to a plan after multiple attempts to contact the enrollee over a generous time period take place. The draft plan should also specify how patients under the care of one or more specialty providers can keep their doctors. In a CHC survey conducted in 2011, fewer than 20% of

220 respondents knew what a medical home was and those that who did know still had difficulty describing it.[1] To automatically enroll individuals into a medical home before they understand how to access care using that model would be a disservice.

2. Minimal or no disruption in continuity of coverage and medical care

Enrollees should be given every opportunity to keep their existing LIHP, primary care, or specialty care provider if desired, regardless of the providers' participation in an approved managed care plan. It is clear from the transition plan that this will be the case for enrollees whose existing medical home is in one or more MMCPs. However, there is less support for individuals who will have to change their plan, primary care provider, or who will see significant disruptions in their specialty care networks. These providers should be identified and made priorities for recruitment. When transitions are necessary, DHCS should clearly communicate options to patients. During the SPD transition, the most prevalent issue concerned patients not being able to or understand how to keep their providers. This should be a lesson learned for the LIHP and all future transitions.

After the SPD transition, patients requested better communication about how to enroll in a new plan, and providers requested more complete medical histories. Both wanted more time for the transition. We recommend that DHCS collaborate with beneficiaries, plans, providers, and other stakeholders to create a continuity of care protocol that will be easy for patients to understand and for providers and plans to implement. To achieve this:

a. LIHP enrollees should be allowed to maintain their existing medical home for at least a year
b. DHCS should help enrollees choose a new plan and provider
c. Beneficiaries who want to or need to change their plan or provider should receive clear instructions.

3. Equitable access to providers for all LIHP enrollees

Access should be assured by working to bring providers into MMCPs through targeted outreach and leveraged federal incentives, with priority given to underserved and under-resourced communities. The influx of new beneficiaries with the Medicaid Expansion in 2014 could stretch the understaffed safety net. The state should start engaging health plans and providers in discussions about how to make the transition of LIHP patients as smooth as possible. In May the Department of Medicare and Medicaid Services released a draft rule that would increase primary care reimbursement for Medicaid up to Medicare levels in 2013 and 2014.[2] DHCS should leverage this incentive to bring providers into MMCPs. We recommend that DHCS begin considering strategies for retaining these providers in the network after the incentive expires in 2014. Beyond looking for ways to maintain the Medicare reimbursement level beyond 2014, the state should consider other incentives for participation such as:

a. Reducing the administrative burden of participation through stakeholder engagement
b. Identifying other potential incentives with providers and plans
c. Clearly communicating the benefits of participating in Medi-Cal
d. Reducing payment delays by investigating and implementing improved payment systems.

[1] Unpublished White Paper "Dialogues with South Los Angeles Safety Net Users on Health Reform." Estimated publication date August 2012.
[2] Proposed Rule. Centers for Medicare and Medicaid Services: Medicaid Program: Payments for Services Furnished by Certain Primary Care Physicians and Charges for Vaccine Administration Under the Vaccines for Children Program. 42 CFR Parts 438, 441, and 447.

The benchmarks for network adequacy that are based on MMCP contracts as well as the estimated patient load on the different MMCP plans should be reported in the final draft plan. Contingency plans for areas with greater than expected gaps between networks or insufficient provider networks should be included.

4. Simple, efficient enrollment and retention processes that are integrated with the ACA to streamline health coverage

Data elements needed for eligibility determination and enrollment should be collected at every encounter. In Los Angeles County, 50% of LIHP enrollees are below 25% FPL.[3] A significant percentage of this population will change their contact information frequently for a variety of reasons. To guarantee the seamless transition of individuals into either Medi-Cal Managed Care Plans or the Exchange, the state should identify and begin collection of the appropriate data elements in Fall 2012 at renewal or provider visits.

LIHP enrollment systems should be integrated with local Medi-Cal enrollment systems and be made compatible with the Statewide Automated Welfare System (SAWS). Counties should begin working now with the SAWS consortiums to use the online public enrollment versions to process LIHP applications. In Los Angeles County, an LIHP portal was developed on the local Medi-Cal system *Your Benefits Now (YBN)* only after major delays in processing enrollment information. While improvements need to be made, it is expected that this will be a major advancement on the slower paper system.

The redetermination date for LIHP enrollees should be changed to reflect their transition date in order to prevent confusion and provide a full year of coverage. For many of the LIHP enrollees, the renewal process under Medi-Cal will be a new experience. To reduce confusion and prevent loss of coverage resulting from failure to return renewal forms to the state, we recommend the Department establish the transition date as the renewal date for the following year. For example, if the LIHP renewal date is February 2014, the individual would be required to undergo the Medi-Cal redetermination process soon after navigating the transition. If this is not feasible, individuals could be afforded additional time on top of the normal 30-day grace period to contact county staff and seek assistance. The state should also work with providers and health plans to assist with the renewal process (i.e., contact families reminding them to return their forms) where possible.

LIHP enrollees should receive timely, consumer-friendly, clear, culturally and linguistically appropriate information about the transition process. The success of the coverage transition relies on the extent to which individuals are able to navigate program changes and maintain coverage. Therefore, we recommend that the department take the following steps:

a. *Include providers and patient advocates when developing the outreach and communication strategy.* The draft transition plan notes that DHCS will partner with local LIHPs and the Exchange; however, we encourage the state to also solicit broad input to ensure effective messaging.

b. *Use every point of communication to provide education about the transition*. Local LIHP staff should be given standardized messages and customizable materials that explain the transition process and what to expect. As much as possible there should also be coordination with statewide ACA marketing efforts.

[3] Low Income Health Program Performance Dashboard: Los Angeles July 11, 2011 – March 31, 2012, UCLA Center of Health Policy Research, June 2012.

c. *Create an orientation packet for LIHP enrollees in all threshold languages that provides basic information about the transition and coverage.* An orientation packet will help reduce consumer confusion and prevent eligibility workers from being bombarded with questions about process and program changes. This orientation packet, specifically the explanation of coverage and benefits, could also be used for all Medi-Cal beneficiaries once enrollment materials have been updated with policy changes as a result of ACA.

d. *Provide consumers with easy to understand information about continuity of care protocols.* With the SPD transition, beneficiaries were confused about a) the steps they could take to keep their existing provider, b) who to contact in the health plan for help, and c) the medical exemption request (MER) process. The department should provide clear information about the roles and responsibilities that DHCS and the health plans will have in preserving their right to care throughout the transition. In addition to being part of the beneficiary orientation packet, informational materials should be developed for providers that can be prominently displayed in offices.

5. Strong infrastructure for consumer focused implementation, communication, and education. The state should ensure that counties, providers, and local community groups serving families who will be impacted by the transition are appropriately prepared to help consumers. In order to ensure that LIHP enrollees are fully supported throughout the transition, we offer the following recommendations:

a. *Have an LIHP liaison or unit in each county and district office (for larger counties) that can respond to questions about and troubleshoot problems related to the transition.* The state should work to model local efforts that facilitate close collaboration and coordination between state and local agencies and organizations/individuals that work with families who will be impacted by the transition.

b. *Preserve the certified application assistor (CAA) program and utilize the CAA network for enrollment support during the transition.* Informing consumers about the enrollment support CAA networks can provide will help take pressure off eligibility workers. Although the role of MRMIB will change, CAAs will continue to be a valuable enrollment and transition resource and not all of them will become exchange navigators.

c. *Provide ongoing trainings for stakeholders on the transition, while allowing individuals to raise enrollment issues and share best practices*. The one training per county provided during the SPD transition was insufficient to prepare providers and community-based organizations for the challenges they faced during the transition. Ongoing meetings/trainings during the initial phases of the transition will minimize confusion among beneficiaries, eligibility workers, and other stakeholders.

d. *State and local county websites should prominently display consumer-friendly information and downloadable materials regarding the transition.* The DHCS and local county websites should provide easy access to materials that consumers and stakeholders can use to explain the transition and link them to enrollment entities, CAAs, and county offices.

Institute a diverse consumer-focused advisory panel (as under MRMIB) to provide input on the transition and other enrollment/eligibility issues related to the Medi-Cal program. The state should model this panel after the Healthy Families Program advisory panel that convened stakeholders,

including consumers, to provide input on all policies, regulations, operations, and implementation of the program. Creating a consistent and transparent process for consumers and consumer advocates to provide input will allow DHCS to create policies that reflect and effectively address the needs of beneficiaries. The advisory panel should include a diverse set of stakeholders, convene outside of Sacramento, and provide call-in/webcast opportunities similar to recent Exchange Board meetings.

We would like to thank the DHCS for the opportunity to provide recommendations on the LIHP Transition plan. On behalf of our partners, we want to encourage you to continue to seek stakeholder input to guarantee the successful transition of LIHP enrollees. We would also like to be a resource on this issue and invite you to meet with our partners to hear their perspectives.

To discuss this letter and a possible meeting, feel free to contact Sonya Vasquez, Policy Director, at 323.295.9372 extension 235.

Sincerely,

Lark Galloway-Gilliam, MPA
Executive Director

cc:
Diane Dooley, Secretary, California Department of Health Care Services
Peter Lee, CA Health Benefits Exchange